Physical Therapy

Which providers are eligible to provide physical therapy?
[Refer to WAC 388-545-500(1)]

- Licensed physical therapists or physiatrists; or
- Physical therapist assistants supervised by licensed physical therapists.

Where must physical therapy services be provided?
[WAC 388-545-500(3)(a)(f)]

MAA reimburses eligible providers for physical therapy services provided as part of an outpatient treatment program in the following settings:

- In an office, home, or outpatient hospital setting;

> ☞ **Note**: Physical therapy may be performed by a home health agency as described in Chapter 388-551 WAC, or as part of an acute physical medicine and rehabilitation (Acute PM&R) program as described in Acute PM&R subchapter 388-550 WAC.

- In a neurodevelopmental center;

- In a school district or educational service district facility as part of an individual education plan (IEP) or individualized family service plan (IFSP), as described in WAC 388-537-0100; or

- For children two years of age and younger with disabilities, in natural environments including the home and community settings in which children without disabilities participate, to the maximum extent appropriate to the needs of the child.

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Referral and Documentation Process

Adults (Age 21 and older) [Refer to WAC 388-545-500 (5)]

Providers must document in a client's medical record that physical therapy services provided to clients age 21 and older are medically necessary. Such documentation may include justification that physical therapy services:

- Prevent the need for hospitalization or nursing home care;
- Assist a client in becoming employable;
- Assist a client who suffers from severe motor disabilities to obtain a greater degree of self-care or independence; or
- Are part of a treatment program intended to restore normal function of a body part following injury, surgery, or prolonged immobilization.

Children (Age 20 and younger)

The EPSDT screening provider must:

- Determine if there is a medical need for physical therapy; and
- Document the medical need and the referral in the child's medical record.

The provider must:

- Keep referral information on file in the form of a prescription, notes from telephone calls, etc.;
- Contact the referring EPSDT provider for information concerning the need for physical therapy services; and
- Keep the referring and/or continuing care provider apprised of the assessment, prognosis, and progress of the referred child.

Coverage [WAC 388-545-500(4)]

MAA reimburses providers for only those covered physical therapy services listed in this section when they are:

- Within the scope of an eligible client's medical care program;
- Medically necessary and ordered by a physician, PA, or an ARNP;
- Begun within 30 days of the date ordered;
- For conditions which are the result of injuries and/or medically recognized diseases and defects; and
- Within accepted physical therapy standards.

> ☞ **Note**: MAA does not limit covered physical therapy services for clients 20 years of age and younger.

Coverage for adults (age 21 and older) [Refer to WAC 388-545-500 (8)]

MAA covers without prior authorization the following physical therapy services per client, per diagnosis:

- One physical therapy evaluation (in addition to the 48 program unit limitation below) per calendar year;
- 48 physical therapy program units per calendar year;
- One visit to instruct the client in the application of transcutaneous electrical neurostimulator (TENS) per lifetime.
- Two DME needs assessments per calendar year (in addition to the 48 program units). Two 15-minute units are allowed per DME needs assessment;
- One wheelchair needs assessment per calendar year (in addition to the two DME needs assessment). Four 15-minute units are allowed per wheelchair assessment).

MAA covers up to 96 physical therapy program units per calendar year in addition to the original 48 units only when:

- The client is diagnosed with one of the following conditions:

ICD-9-CM Diagnosis Codes	Condition
315.3-315.9, 317-319	Medically necessary conditions for individuals identified as having developmental disabilities
343 - 343.9	Cerebral palsy
741.9	Meningomyelocele
758.0	Down syndrome
781.2 - 781.3	Symptoms involving nervous and musculoskeletal systems, lack of coordination
800 - 829.1	Surgeries involving extremities – Fractures
851 - 854.1	Intracranial injuries
880 - 887.7	Surgeries involving extremities - Open wounds with tendon involvement
941 - 949.5	Burns
950 - 957.9, 959 - 959.9	Traumatic injuries

☞ **Note**: The conditions above **must** be listed as the primary diagnosis on the claim.

-OR-

- The client no longer needs nursing services, but continues to require specialized outpatient physical therapy as part of a recently approved Acute PM&R program (within the previous 12 months) for the following conditions:

ICD-9-CM Diagnosis Codes	Condition
854	Traumatic brain injury
900.82, 344.0, 344.1	Spinal cord injury (paraplegia and/or quadriplegia)
436	Recent or recurrent stroke
340	Restoration of the levels of function due to secondary illness or loss for multiple sclerosis
335.20	Amyotrophic lateral sclerosis
343 - 343.9	Cerebral palsy
357.0	Acute infective polyneuritis (Guillain-Barre' syndrome)
941.4, 941.5, 942.4, 942.5, 943.4, 943.5, 944.4, 944.5, 945.4, 945.5, 946.4, 946.5	Extensive severe burns
344.0, 707.0	Skin flaps for sacral decubitus for quads only
890 - 897.7, 887.6 - 887.7	Open wound of lower limb, bilateral limb loss

Physical Therapy Program Limitations

MAA does not cover duplicate services for occupational and physical therapy for the same client when both providers are performing the same or similar procedure(s). [WAC 338-545-500 (11)]

> ☞ **Note**: A program unit is based on the CPT code description. For CPT codes that are timed, each 15 minutes equals one unit. If the description does not include time, the procedure equals one unit regardless of how long the procedure takes. If time is included in the CPT description, the beginning and ending times of each therapy modality must be documented in the client's medical record.

The following are considered part of the physical therapy program 48-unit limitation:

- Application of a modality to one or more areas not requiring direct patient contact (CPT codes 97010-97028).
- Application of a modality to one or more areas requiring direct patient contact (CPT codes 97032-97039).
- Therapeutic exercises (CPT codes 97110-97139).
- Manual therapy (CPT code 97140).
- Therapeutic procedures (CPT code 97150).
- Prosthetic training (CPT code 97520).
- Therapeutic activities (CPT code 97530).
- Self-care/home management training (CPT code 97535).
- Community/work reintegration training (CPT code 97537).
- Physical performance test or measurement (CPT code 97750). Do not use to bill for an evaluation (CPT code 97001) or re-evaluation (CPT code 97002).
- Assistive technology assessment (CPT code 97755).

The following are not included in the physical therapy program 48-unit limitation:

- Muscle testing (CPT codes 95831-95852). MAA covers one muscle testing procedure per day. Muscle testing procedures cannot be billed in combination with each other. These procedures can be billed alone or with other physical therapy CPT codes.

- Physical therapy evaluation (CPT code 97001). Use for reporting the initial evaluation before the plan of care is established by the physical therapist or the physician. This procedure is not used for re-evaluating the client's condition and establishing the plan of care.

- Physical therapy re-evaluation (CPT code 97002). Allowed once per client, per calendar year. Use for reporting the re-evaluation of a client who has been under a plan of care established by a physician or physical therapist. This procedure is for re-evaluating the client's condition and revising the plan of care under which the client is being treated.

- Orthotics fitting and training upper and/or lower extremities (CPT code 97504). MAA covers two units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Active wound care management involving selective and non-selective debridement (CPT codes 97601 and 97602). The following conditions apply:

  - ✓ MAA covers one unit of CPT code 97601 or 97602 per client, per day. Providers may not bill CPT codes 97601 and 97602 in conjunction with each other.

  - ✓ Providers must not bill CPT codes 97601 and 97602 in addition to CPT codes 11040-11044.

- Checkout for orthotic/prosthetic use (CPT code 97703). MAA covers two 15-minute units per day. This procedure can be billed alone or with other physical therapy CPT codes.

- Wheelchair needs assessment (CPT code 97703). MAA covers one wheelchair needs assessment per client, per calendar year, limited to four 15-minute units per assessment. Indicate on the claim that this is a wheelchair needs assessment.

- DME needs assessments (CPT code 97703). MAA covers two DME needs assessments per client, per calendar year, limited to two 15-minute units per assessment. Indicate on the claim that this is a DME needs assessment.

- Splints (refer to Section K for those splints covered in a provider's office).

How do I request approval to exceed the limits?

For clients 21 years of age and older who need physical therapy in addition to existing program unit limitations, the provider must request a Limitation Extension (LE). See Section I – Prior Authorization.

Are school medical services covered?

MAA covers physical therapy services provided in a school setting for school-contracted services that are noted in the client's Individual Education Program (IEP) or Individualized Family Service Plan (IFSP). Refer to MAA's School Medical Services Billing Instructions. (See Important Contacts.)

What is not covered? [WAC 388-545-500(12)]

MAA does not reimburse separately for physical therapy services that are included as part of the reimbursement for other treatment programs. This includes, but is not limited to, hospital inpatient and nursing facility services.

Miscellaneous Services

Acute Physical Medicine and Rehabilitation (Acute PM&R): Inpatient PM&R is limited to MAA-contracted facilities.

DDD Physical: MAA covers one physical every 12 months for clients with disabilities. Providers must bill using HCPCS code T1023 with modifier HI.

HIV/AIDS Counseling: MAA covers two sessions of risk factor reduction counseling (CPT code 99401) for HIV/AIDS counseling per client, per lifetime. [Refer to WAC 388-531-0600] Use ICD-9-CM diagnosis code V65.44 when billing CPT code 99401 for HIV/AIDS counseling.

Needle Electromyography (EMGs): MAA has adopted Medicare-established limits for billing needle EMGs (CPT codes 95860 – 95870) as follows:

CPT Code	Brief Description	Limits
95860 95861 95863 95864	Needle EMG; one extremity with or without related paraspinal areas two extremities… three extremities… four extremities…	• Extremity muscles innervated by three nerves or four spinal levels must be evaluated with a minimum of five muscles studied.
95869	Needle EMG; thoracic paraspinal muscles	• Limited to one unit per day. • For this to pay with extremity codes 95860-95864, test must be for T3-T11 areas only; T1 or T2 alone are not separately payable.
95870	Needle EMG; other than thoracic paraspinal, cranial nerve supplied muscles, or sphincters	• Limited to one unit **per extremity**, and one unit for cervical or lumbar paraspinal muscle, regardless of number of levels tested (maximum of 5 units). • Not payable with extremity codes (CPT codes 95860-95864).

TB Treatment Services Performed by Non-Professional Providers: Health Departments billing for TB treatment services provided by **non-professional providers** in either the client's home or in the office must bill using HCPCS code T1020 (personal care services). Do not bill the initial visit with a modifier. Follow-up visits must be billed using T1020 with modifier TS (follow-up services modifier).

Cochlear Implant Services [Refer to WAC 388-531-0200(4)(c)]

- Cochlear implantation (CPT code 69930) requires prior authorization (refer to Section I – Prior Authorization). Providers must send in medical documentation to justify the need for cochlear implants. In particular, MAA requires information on how the client was counseled on the different options for dealing with hearing loss such as, but not limited to, manual language.

- MAA reimburses providers for replacement parts for cochlear implants given directly to the client using HCPCS code A9900. Prior authorization is required for the replacement parts. Pricing is determined by the authorization section.

- When reimbursing for battery packs, MAA covers the **least costly, equally effective** product.

Vagus Nerve Stimulation (VNS) [Refer to WAC 388-531-0200(h)]

- Vagus nerve stimulation (CPT codes 61885, 64573, and 64585) requires prior authorization (refer to Section I - Prior Authorization).

  Exception: CPT codes 61885 and 61886 **do not** require prior authorization when billed in conjunction with CPT code 61862 **and** the ICD-9-CM diagnosis is 333.1 or 332.0.

- VNS procedures can be performed in an inpatient hospital or outpatient hospital setting.

- Prior authorization is not required for VNS programming (CPT codes 95970, 95974, and 95975) performed by a neurologist.

Osseointegrated Implants

- Insertion of osseointegrated implants (CPT codes 69714-69718) requires prior authorization (refer to Section I - Prior Authorization).

- The procedure can be performed in an inpatient hospital setting or outpatient hospital setting.

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